# LEGAL RESPONSES TO CROSS-BORDER MOVEMENT IN REPRODUCTIVE MATTERS WITHIN THE EUROPEAN UNION

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## 1. INTRODUCTION

Reproductive matters are a profound example of a moral and ethical issue in respect of which the legal regimes of the Member States of the European Union (EU) differ considerably.[2] States have – often consciously – made different choices in respect of abortion, assisted human reproduction (AHR) and surrogacy. Regimes differ with respect to legality of and access to these services, with respect to reimbursement for treatment, as well as regarding the rights and recognition of children born following reproductive treatment.

This diversity in regimes is one of the major reasons why phenomena like cross-border abortions, cross-border reproductive care (CBRC) and cross-border surrogacy have occurred over the past decades.[3] Although exhaustive statistics on the scale of such cross-border movement within the EU are lacking, the existence of these phenomena cannot be denied. For example, the European Society of Human Reproduction and Embryology (ESHRE) estimated in 2008 that at least 11,000-14,000 services recipients are involved in cross-border reproductive care (CBRC) within the EU every year.[4] As the study acknowledged, these numbers may be even

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[2] The author would like to underline that even though the present paper deals with ethical and moral issues, it does not express her personal views on these matters.

[3] *Inter alia* ESHRE, *Comparative Analysis of Medically Assisted Reproduction in the EU: Regulation and Technologies*, 2008, SANCO/2008/C6/051, Annex 6a, p. 136-137.

[4] *Idem*, p. 78. For other studies on CBRC see *inter alia* F Shenfield a.o., 'Cross border reproductive care in six European countries', *Human Reproduction*, Vol. 25 (2010) No. 6, p. 1361-1368 and G Pennings a.o., 'ESHRE Task Force on Ethics and Law 15: Cross-border reproductive care', *Human Reproduction* Vol. 23 (2008) No.10, p. 2182-2184. See also A Coverleyn a.o., *Pre-implantation Genetic Diagnosis in Europe*, Joint Research Centre of the European Commission, online available at <http://ftp.jrc.es/EURdoc/eur22764en.pdf> (last accessed 29 March 2014). Incidentally these statistics include reports of surrogacy cases. Further evidence proving the existence of cross-border surrogacy can be found in case-law from various national courts as discussed in sections 3.1.1 and 3.2.1 below. Such cross-border movement seems to take place primarily to states outside the EU, such as Ukraine and certain States of the United States of America, where commercial surrogacy is legalised.

higher in reality. Further, they may have increased since the year 2008 and may continue to increase in the future.

States consequently are more and more often confronted with one another's regimes. This raises a number of difficult questions. One of these is if States should accommodate (the effects of) different foreign choices in reproductive issues or whether they can protect their own standards, for instance by refusing reimbursement for treatment obtained abroad or by invoking public policy clauses in cases of cross-border surrogacy. Another question is if States are or should be allowed to hide behind other States' regimes, and outsource the protection of rights in these sensitive matters, by referring to the laws of other States. Within the special multilevel context of the EU, these questions gain even more depth, particularly now that an area is concerned in which the EU has no or (very) limited competences.[5]

Section 3 of this paper explores and typifies various (potential) legal responses at national level to cross-border movement in reproductive matters. It is thereby assessed how these are influenced by perspectives like equality and the interests of the (unborn or future) child. Also, it is examined to what extent European law leaves room for such responses at national level, or may even dictate certain legal responses. In order to give a framework to that assessment, section 2 firstly sets out the relevant standards in reproductive matters, under both EU law and the European Convention on Human Rights (ECHR).[6] Section 2 shows that States are granted States considerable room under European law to make their own (moral and ethical) choices in reproductive matters, but certain standards and principles must nonetheless be observed. These standards and principle may prove also – or perhaps even more – relevant in cross-border situations. Section 2 thus lays a basis for section 3, where discussion of the various legal responses leads to the identification of an emerging European framework for cross-border movement in reproductive matters.

# 2. EUROPEAN LAW AND REPRODUCTIVE MATTERS

## 2.1 EU LAW

At EU level there is very little substantive standard setting in the field of reproductive matters. For example, there is no EU legislation that obliges the Member States to legalise abortion, or to prohibit AHR treatment with the use of donor gametes. In respect of these sensitive issues the

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In respect of cross-border abortions, one is only reminded that between 1980 and 2012, at least 156,076 women travelled from the Republic of Ireland for safe abortion services abroad (see <http://www.ifpa.ie/Hot-Topics/Abortion/Statistics> (last accessed 29 March 2014)). However, as not all EU Member States keep statistics of the number of abortions carried out within their territory at an annual basis, let alone the number of non-national or non-resident women involved in these abortions, there are no statistics available on the total number of cross-border abortions within the EU. See also M Gissler a.o. (the REPROSTAT group), 'Terminations of pregnancy in the European Union', *BJOG An International Journal of Obstetrics and Gynaecology*, 2011, p. 7.

[5] See section 2.1.

[6] Following Article 6 (3) TEU fundamental rights, as guaranteed by the ECHR and as they result from the constitutional traditions common to the Member States, constitute general principles of EU law.

EU Member States have not been very willing to transfer competences to the Union; in respect of health the EU has a coordinating competence only,[7] while in the field of family law it has no competence at all, except when measures concerning family law 'having cross-border implications' are concerned.[8]

There are two EU Directives which deal with AHR-related matters, but their substantive standard-setting in the area is fairly limited. The In vitro diagnostic medical devices Directive (1998)[9] provides for harmonisation of national provisions governing the placing on the market of so-called *in vitro* diagnostic medical devices, including *in vitro* fertilisation and assisted reproduction technologies products. Under this Directive Member States may not create any obstacle to the placing on the market or the putting into service within their territory of *in vitro* diagnostic medical devices which meet certain (design and manufacturing) requirements. The Directive does, however, not affect their ability to regulate – or even prohibit – the *use* of such devices within their territory. The Tissues and Cells Directive (2004)[10], on the other hand, deals with more substantive AHR-issues, but its harmonising effect is limited. It provides that Member States must 'endavour to ensure' voluntary and unpaid donations of gametes.[11] Also, as a matter of principle, such donation must be anonymous, although this is 'without prejudice to legislation in force in Member States on the conditions for disclosure, notably in the case of gametes donation'.[12] States are furthermore free to prohibit the donation, processing or procurement of gametes, they may prohibit or restrict the import of such cells and they are free to introduce requirements for voluntary unpaid donation.[13] The latter effectively limits the harmonizing effect of this Directive in the field of AHR.[14]

The EU Charter of Fundamental Rights contains various rights that are (potentially) relevant for reproductive matters – such as the right to human dignity, the right to physical integrity (including the prohibition of eugenic practices), the right to respect for private and family life and the rights of the child[15] – but application of the Charter is only triggered in issues that come within the scope of EU law.[16] Most scenario's involving reproductive matters are, however, excluded from the scope of EU law, rendering the potential of these rights in the context of reproductive matters thus also limited. This may be different in cross-border situations, as further explained in section 3.2.1 below.

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[7] Articles 4 (2) (k) , Article 6 (a) and Article 168 TFEU.
[8] Article 81 (3) TFEU.
[9] Directive 98/79/EC, *OJ* L 331/1 (7.12. 1998)
[10] The Tissues and Cells Directive is made up of the parent Directive 2004/23/EC, *OJ* EU L 102/48 (07.04.2004) and two technical directives (Directive 2006/17/EC, *OJ* L 38/40 (09.02.2006) and Directive 2006/86/EC, *OJ* L 294/32 (25.10.2006)).
[11] Article 12 (1), Article 3 (a) and Recital no. 7 Directive 2004/23/EC. Donors may receive compensation, but this is 'strictly limited to making good the expenses and inconveniences related to the donation procedure.' Member States define the conditions under which the compensation may be granted. The Commission considered the paying of substantial fees to obtain human egg cells to be against the principles expressed in Directive 2004/23/EC. See European Commission, Report on the Regulation of Reproductive Cell Donation in the European Union, February 2006, p. 2, online available at: <http://ec.europa.eu/health/archive/ph_threats/human_substance/documents/tissues_frep_en.pdf> (last accessed 29 March 2014).
[12] Article 9 and Article 14 (1) and (3) Directive 2004/23/EC.
[13] Article 4 (2) and (3) Directive 2004/23/EC.
[14] It is also expressly provided in Recital no. 12 that the Directive is not to interfere 'with provisions of the Member States defining the legal term 'person' or 'individual'.'
[15] Articles 1, 3, 7 and 24 CFR respectively.
[16] See Article 51 (1) CFR. See also *Akerberg*, C-610/11, judgment of 26th February 2013 *nyr*., para. 21.

The (potential) relevance of the EU's non-discrimination law for issues like access to reproductive treatment is also limited. The current framework prohibits discrimination on grounds such as age and sexual orientation, but it applies to employment, occupation and vocational training only.[17] A proposal for a more general Equal Treatment Directive has been on the table for a long time now, which intends to expand the reach of EU law to matters like social protection, health care and access to goods and services which are available to the public.[18] Reproductive rights were, however, explicitly excluded from the scope of the Directive as proposed by the Commission and as yet the proposal has not been amended on this point, despite certain amendments to this effect.[19] In fact, given the amount of controversy surrounding the proposal as a whole, it seems doubtful if the Directive will ever be adopted at all.[20]

Thus far, the Court of Justice of the European Union (CJEU) has also been offered little opportunity to pronounce itself on reproduction related matters. Only a few employment cases have some, albeit a very limited, impact on the substantive regulation of these matters in the Member States. For example, in *Sabine Mayr* (2008) the Court held that the protection of EU law of pregnant workers against dismissal extends to women who are in 'an advanced stage of *in vitro* fertilization treatment'.[21] Mindful of the fact that 'artificial fertilisation and viable cells treatment is a very sensitive social issue in many Member States, marked by their multiple traditions and value systems', the CJEU made very clear that it gave a 'legal interpretation' of the relevant provisions of the relevant Directive 92/85 only, and that it was not called upon 'to broach medical or ethical questions'.[22] A similar caution was issued in a later case in the area of patent law, where the Court however accorded a certain protection to the human embryo by holding that a process entailing its destruction could not be patented.[23] Further, in its recent judgments in the cases *C. D* and *Z.* (2014), the CJEU was rather firm in holding that EU law did not provide for any entitlements for commissioning mothers who had a child through a surrogacy agreement to paid leave equivalent to maternity leave or adoption leave.[24]

There are various open questions as to the application of the EU law to cross-border movement in reproductive matters. While there is an extensive body of EU law on cross-border health care in general, little is provided for the specific areas of cross-border reproductive care, cross-border abortions and cross-border surrogacy.[25] There is also hardly any CJEU case-law on the

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[17] Directive 2000/78/EC, *OJ* L 303/16 (2.12.2000).

[18] Proposal for a Council Directive on implementing the principle of equal treatment between persons irrespective of religion or belief, disability, age or sexual orientation, Brussels, 2.7.2008, COM(2008) 426 final.

[19] Article 3 (2) and Recital No. 17 of the proposed Directive. See *OJ* C 182/21 (4.8.2009) and *OJ* C 137E/75 (27.05.2010).

[20] For the state of affairs, see <http://ec.europa.eu/prelex/detail_dossier_real.cfm?CL=en&DosId=197196#397912> (last accessed 29 March 2014).

[21] The Court defined an 'advanced stage' of IVF treatment as 'between the follicular puncture and the immediate transfer of the in vitro fertilised ova into [a woman's] uterus'. *Sabine Mayr*, C-506/06, judgment [GC] of 26 February 2008 [2008] ECR I-01017, para. 53-54.

[22] *Idem,* para. 38,

[23] *Oliver Brüstle*, C−34/10, judgment [GC] of 18 October 2011 [2011] ECR I-09821, para. 30. In this case the Court ruled that a process which involves removal of a stem cell from a human embryo at the blastocyst stage, entailing the destruction of that embryo, cannot be patented.

[24] *C. D. v S.T.*, C-167/12, judgment [GC] of 18 March 2014, *nyr*. and *Z.*, C-363/12, judgment [GC] of 18 March 2014, *nyr*.

[25] Primarily two EU law regimes apply to matters concerning access to and reimbursement for cross-border health care. These are the Social Security Regulation (Regulation (EC) No 883/2004, *OJ* L 166 (30.04.2004)) and the free movement rules, as currently laid down in Articles 28-39 and 45-66 TFEU. Various of the principles as developed in the CJEU's case law on cross-border health care have subsequently been codified in the Patient Mobility Directive (Directive 2011/24/EU

application of the relevant instruments and the general EU free movement rules to these situations. What is clear, however, is that abortion and AHR treatment, being medical activities, fall within the definition of 'services' within the meaning of the TFEU, provided they are legally provided for remuneration in at least one EU Member State.[26] Surrogacy may in itself also be considered a service.[27] The freedom to provide and receive services is, however, not unlimited and may be restricted. Such a restriction may, of course, in itself be considered a legal response to cross-border movement. Section 3.1 discusses such restrictions in cases concerning reproductive matters and assesses if they can (potentially) be justified under EU law. In all cross-border situations fundamental rights, including those as guaranteed by the ECHR must be observed,[28] rendering it even more important to examine what level of protection is required under the ECHR in reproductive matters.

## 2.2 The European Convention on Human Rights

At the Council of Europe level it is mainly the case-law of the European Court of Human Rights (ECtHR) on the basis of the ECHR that has impacted national standard-setting in reproductive matters.[29] The ECtHR's case-law in this area, while still fairly limited, is steadily expanding. There have been various abortion cases decided by the Court, and also a few cases concerning AHR. So far the ECtHR has not ruled in in any surrogacy case, but as further discussed below, there are interesting cases pending before the Court.[30]

Reproductive matters come within the scope of the ECHR, as they fall under the right to respect for private life (Article 8 ECHR). The Court has, for instance, ruled that the decision of a pregnant

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*OJ* L 88/46 (4.4.2011)) which, in fact, now constitutes the third applicable regime. See also S de la Rosa, 'The directive on cross-border healthcare or the art of codifying complex case law', *CML Rev.* 49, 2012, p. 22.

[26] *Grogan*, C-159/90, judgment of 4 October 1991 [1991] ECR I-04685, paras. 17-18. In this case the Court explicitly held so in respect of termination of pregnancy. Only if it is outlawed by *all* Member States, may a service be excluded from the scope of the EU free movement rules (Cf. *Josemans*, C-137/09, judgment of 16 December 2010 [2010] ECR I-13019). Abortion and AHR treatment can also be considered 'health care' within the meaning of the Patient Mobility Directive (2011/24/EU). Recital 7 to this Directive makes very clear however, that the Directive 'respects and is without prejudice to the freedom of each Member State to decide what type of healthcare it considers appropriate' and that no provision of the Directive 'should be interpreted in such a way as to undermine the fundamental ethical choices of Member States.'

[27] See also L Brunet a.o., *A Comparative Study on the Regime of Surrogacy in EU Member States*, 2013, PE 474.403, p. 142-143 (online available at <http://www.europarl.europa.eu/RegData/etudes/etudes/join/2013/474403/IPOL-JURI_ET(2013)474403_EN.pdf> (last accessed 31 March 2014).

[28] See *n* 6.

[29] Certain standards on the regulation of AHR are further set by the Convention on Human Rights and Biomedicine (1997, CETS No: 164). Its Article 12 provides that genetic testing is permitted for health purposes only. Article 14 prohibits the use of techniques of medically assisted procreation with the purpose of sex-selection, except where serious hereditary sex-related disease is to be avoided. Because not all EU Member States have ratified this Convention, these standards do not apply throughout the entire European Union. For the latest status of ratifications see: <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=164&CM=&DF=&CL=ENG> (last accessed 30 March 2014).

[30] *Mennesson and Others v France*, no. 65192/11, case communicated on 12 February 2012; *Labassee v France*, no. 65941/11, case communicated on 12 February 2012; *Paradiso and Campanelli v Italy*, no. 25358/12, case communicated on 9 May 2012 and *D and R v Belgium*, no. 29176/13, case communicated on 19 November 2013. See also section 3.2.1.

woman to continue her pregnancy or not comes within the scope of Article 8.[31] Also, the notion 'private life' of Article 8 includes a right to respect for the decision to become a (genetic) parent.[32] This includes 'the right of a couple to conceive a child and to make use of medically assisted procreation for that purpose'.[33] These rights, however, do not enjoy very strong protection under the Convention. The Court generally leaves States a wide margin of appreciation in dealing with these moral and ethical issues, which involve a complex balancing of various individual interests.[34] It has accordingly held that the right to respect for private life as protected under Article 8 ECHR cannot be interpreted as conferring a right to abortion[35] and that the Convention does not cover a right to procreation.[36] Also, it never pronounced itself upon the question whether the unborn child is a person for the purposes of Article 2 ECHR (the right to life)[37] and has left it to States to decide whether a right to know ones genetic parents is protected at national level.[38] As a result, even far-reaching interferences with Article 8 in reproductive matters have been held not to violate the Convention. In the abortion case of *A, B and C v Ireland* (2010), for example, the Grand Chamber of the Court held that a complete prohibition on abortions for health and/or well-being reasons constituted no violation of Article 8, but fell within the State's margin of appreciation.[39] The Court thereby had regard to the fact that Irish women could lawfully travel abroad for an abortion with access to appropriate information and medical care in Ireland.[40] In *S H and Others v Austria* (2011), the Grand Chamber held that an absolute prohibition on the use of donated gametes in the course of IVF-treatment did not exceed the respondent State's margin of appreciation. In that case the Court explained that the margin of appreciation afforded to the respondent State was a wide one 'since the use of IVF treatment gives rise to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the case touch on areas where there is no clear common ground amongst the Member States'.[41]

While it is very common in the ECtHR case-law that a lack of consensus widens the margin of appreciation of the State, the Court has introduced some variations on its well-established doctrine especially in the context of reproductive rights. In *S H and Others,* for example, the Court seemed to set the barrier higher than it had done so far in its case-law, by holding that for a common ground to decisively narrow the margin, it had to be 'based on settled and long-

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[31] *Inter alia* ECieHR (dec.) 19 May 1976, *Brüggeman and Scheuten v Germany*, no. 6959/75; ECtHR (dec.) 5 September 2002, *Boso v Italy*, no. 50490/99; ECtHR [GC] 8 July 2004, *Vo v France*, no. 53924/00, para. 76, ECtHR 20 March 2007, *Tysiąc v Poland*, paras. 106-107 and ECtHR [GC] 16 December 2010, *A, B and C v Ireland*, no. 25579/05, para. 212. In a more recent case, the Court spoke of 'the right to decide on the termination of a pregnancy', but at the same time stressed that this right is not absolute. ECtHR 30 October 2012, *P and S v Poland*, no. 57375/08, para. 98.

[32] *Inter alia* ECtHR [GC] 10 April 2007, *Evans v the United Kingdom*, no. 6339/05, para. 71 and *A, B and C* (*n* @), para. 212.

[33] ECtHR [GC] 3 November 2011, *S.H. and Others v Austria,* no. 57813/00, para. 82.

[34] *Inter alia Evans* (*n* 32), para. 77 and *A, B and C* (*n* 31), para. 233.

[35] *A, B and C* (*n* 31), para. 214.

[36] ECtHR (dec.) 6 March 2003, *Margarita Šijakova and Others v "the former Yugoslav Republic of Macedonia"*, no. 67914/01 and ECtHR (dec.) 15 November 2007, S.H. and others v Austria, no. 57813/00.

[37] *Vo* (*n* 31), para. 85.

[38] *Inter alia* ECtHR 13 February 2003, *Odièvre v France*, no. 42326/98 and ECtHR 22 March 2012, *Ahrens v Germany*, no. 45071/09.

[39] *A, B and C* (*n* 31), para. 241.

[40] The implications of this finding are further discussed below under sections @ and @.

[41] *S H and Others* (*n* 33), para. 97.

standing principles established in the law of the member States'.[42] In the abortion case *A, B and C* the Court took an unprecedented approach in defining the issue on which such consensus had to exist. While the Court acknowledged that there was indeed a consensus amongst a substantial majority of the Contracting States of the Council of Europe towards allowing abortion 'on broader grounds than accorded under Irish law', this consensus did not decisively narrow the broad margin of appreciation of the State, because there was no European consensus on the question whether the unborn was a person to be protected for the purposes of Article 2 ECHR.[43]

As these variations on the margin of appreciation doctrine illustrate, the Court is thus very reluctant to intervene in reproductive matters. States are left much room to introduce change at their own pace, as long as the competing interests have been weighed in the national legislative process, and as long as they keep this area under review.[44] Potentially less room is left to States under the ECHR when cross-border situations are concerned.[45]

Moreover, it must be borne in mind, that the Convention only sets a minimum standard and that States are free to offer a higher level of protection to the Convention rights. Interestingly, it is exactly in that situation that the Convention has a more implicit impact. While principled choices in reproductive matters are left to the States, the fact that reproductive matters come within the scope of the Convention means that, as soon as a State regulates this area of law, certain general obligations resulting from the Convention apply. These entail that (1) the right or entitlement granted at national level must be effective; (2) the relevant legislation must be coherent and (3) the right or entitlement must be granted in a non-discriminatory manner.

Following settled case-law the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective.[46] In the abortion context this has been held to mean that *if* a legislator allows for abortion in certain circumstances, it also has to protect certain procedural rights. The relevant procedure 'should guarantee to a pregnant woman at least a possibility to be heard in person and to have her views considered',[47] the competent body or person should issue written grounds for its decision[48] and the pregnant woman should have effective access to relevant information on her and the foetus' health.[49] The latter includes access to diagnostic services, decisive for the possibility for the pregnant woman of exercising her right to take an informed decision as to whether to seek an abortion or not.[50]

States must furthermore shape their legal framework in the area of reproductive matters 'in a coherent manner which allows the different legitimate interests involved to be adequately taken into account.'[51] On the basis of such coherency reasoning the Court has considered Italian

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[42] *Idem,* para. 96.
[43] *A, B and C* (*n* 31), paras. 235-237.
[44] *S H and Others* (*n* 33), paras. 103 and 118. The Court accepted that States adopt rules in this area which do not provide for the weighing of competing interests in the circumstance of each individual case. *S H and Others* (*n* 33), para. 110.
[45] This point will be further developed in sections 3 and 4.
[46] ECtHR 9 October 1979, *Airey v Ireland*, no. 6289/73. See also ECtHR 30 October 2012, *P and S v Poland*, no. 57375/08, para. 99.
[47] *Tysiąc* (*n* 31), para. 113.
[48] *Idem.*
[49] ECtHR 26 May 2011, *R R v Poland*, no. 27617/04, para. 197.
[50] *Idem*, para. 208.
[51] *S H and Others* (*n* 33), para. 100.

legislation that denied a couple access to Pre-implantation Genetic Diagnose (PID) in the course of AHR treatment but authorised medically-assisted termination of pregnancy if the foetus showed symptoms of the same disease, incoherent and inconsistent.[52] As a result, the couple was left with only one choice, which moreover brought anxiety and suffering, namely to start a pregnancy by natural means and terminate it if prenatal tests showed the foetus to have the disease. Noting and stressing that this concerned a specific case, which affected apart from Italy only two more High Contracting Parties, the Court concluded that the interference with the applicants' right to respect for their private and family life was disproportionate.

Thirdly, rights and entitlements that come within the scope of the Convention must be awarded in a non-discriminatory manner.[53] In *S H and others* the Chamber had found a violation of the Convention on the basis of such reasoning,[54] but this was later overruled by the Grand Chamber. The non-discrimination requirement may be applied in cases where same-sex couples claim access to AHR treatment. In *Gas and Dubois v France* (2012), however, the Court held the applicants, a same-sex couple, to be not in a similar situation to infertile heterosexual couples.[55] The potential of this non-discrimination requirement in cross-border situations must yet be explored. It may limit the States' room for responding to cross-border movement in reproductive matters, although it is also possible that the Court takes a fairly narrow approach in defining the relevantly similar situations.

The ECtHR's case-law in the area of reproductive matters thus has its own dynamic. States can maintain very restrictive regimes and they are given ample room to introduce change at their own pace, but as soon as they make one step in the direction of awarding more rights in this field, they also have to meet certain (procedural) obligations that effectively limit their freedom in these complex matters. In other words, the Court's line of reasoning may lead to a sharper divide in Europe in these matters. These implications of the ECtHR's case-law may be partially alleviated by another unique line of reasoning of the Court which seems to imply that States can outsource their obligations under the Convention in this sphere, as long as they meet certain minimum obligations. This point is further developed in the following section where legal responses to cross-border movement in reproductive matters are discussed.

## 3. LEGAL RESPONSES TO CROSS-BORDER MOVEMENT

States may react and respond to cross-border movement in reproductive matters in various ways. This section explores a number of (potential) legal responses of States that function as countries of origin in these situations.[56] Being confronted with one another's regimes, States may try to protect their own standards, by warding off (the effects of) such cross-border movement. States may also take a more pragmatic approach and accommodate for (the effects

[52] ECtHR 28 August 2012, *Costa en Pavan v Italy*, no. 54270/10.
[53] Article 14 ECHR. See *inter alia* ECtHR [GC] 19 February 2013, *X and Others v Austria*, no. 19010/07.
[54] ECtHR 1 April 2010, *S H and Others v Austria*, no. 57813/00.
[55] ECtHR 15 March 2012, *Gas and Dubois v France*, no. 25951/07, para. 63.
[56] It is, however, not inconceivable that States with more permissive regimes in reproductive matters that function as destination countries may wish to ward off or instead encourage cross-border movement towards their country.

of) different foreign choices in reproductive issues.[57] Lastly cross-border movement may enable States to hide behind other States' regimes and to outsource the protection of rights in these sensitive matters. Principled and protectionist legal responses are discussed in section 3.1, while accommodating responses are discussed in 3.2 and section 3.3 discusses outsourcing. It thereby is explored to what extent European law leaves room for each of responses, or even dictates them. As will become clear from that exercise, there are as yet various open questions in respect of the implications of European law in this area. Nonetheless an emerging rule system applying to cross-border situations in reproductive matters can be identified

## 3.1 WARDING OFF

Legal responses that intend to ward off (the effects of) cross-border movement in reproductive matters may take different shapes. The most far reaching principled response consists in trying to prevent such cross-border movement from taking place in the first place, for instance by imposing a travel ban, or by criminally prosecuting for involvement in treatment obtained abroad.[58] While space does not allow an extensive legal analysis on this point, it is submitted that such travel bans and criminal prosecutions are hard to justify under EU free movement law.[59] In any case, there have only been incidental reports of such far reaching measures being taken by EU Member States.[60] Given the drastic nature of such measures and difficulties in enforcing them,[61] States are more likely to resort to other, nonetheless principled, legal responses. For example, as discussed in section 3.1.1, they may refuse to recognise the legal effects of foreign treatment options. They may also (wish to) ban information about such foreign options (section 3.1.2), refuse reimbursement for treatment obtained abroad (section 3.1.3) or refuse follow-up care upon return (section 3.1.4).

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[57] The terms 'principled', 'protectionist' and 'pragmatic' are used descriptive and not normative.

[58] See also R F Storrow, 'Assisted Reproduction on treacherous terrain: the legal hazards of cross-border reproductive travel', *Reproductive BioMedicine Online* (2011) 23, p. 538-545 and W van Hoof and G Pennings, 'Extraterritoriality for cross-border reproductive care; should states act against citizens travelling abroad for illegal infertility treatment?', *Reproductive BioMedicine Online* (2011) 23, p. 546-554. In Turkey a law was introduced in 2010 following which individuals who travelled abroad for AHR treatment involving donated gametes or surrogacy, could be prosecuted. Z B Gürtin, 'Banning reproductive travel: Turkey's ART legislation and third-party assisted reproduction, *Reproductive BioMedicine Online* (2011) 23, p. 555-564.

[59] Cf. *Grogan*, C-159/90, Opinion of Advocate General Van Gerven of 11 June 1991 [1991] ECR I-4703, para. 35.

[60] A unique example of a case where an EU Member State imposed a travel ban in this context concerns the Irish *X-case*. A 14-year-old girl who was pregnant as a result of multiple rape and wished to travel to the United Kingdom to have an abortion, was prevented by Court order from leaving Ireland for a period of nine months. On appeal the injunction was lifted. The Irish Supreme Court decided the case – including its travel aspect – on the basis of national law only, thereby avoiding issues of European free movement law. *Attorney General v X* [1992] 1 IR 1 at 53, [1992] ILRM 401 at 425, [1992] 2 *CMLR* 277 at 300. Soon after the judgment the Irish Constitution was amended; section 40.3 which protects the right to life of the unborn, now provides that it not does not limit freedom to travel between the State and another state.
Prosecution practice in the area of reproductive matters is generally low. An example of an incidental report of criminal prosecution by an EU Member States for treatment obtained in another Member States comes from the Netherlands. In 2008 charges were brought against a Dutch woman who had an abortion after 28 weeks of pregnancy, in a controversial abortion clinic in Spain. The charges were later dropped on grounds of the special circumstances of the case. 'OM staakt vervolging late abortus in Spanje', *NRC Handelsblad*, 4 December 2008, p. 2.

[61] Van Hoof and Pennings 2011 (*n* 58), p. 551.

### 3.1.1 NON-RECOGNITION OF LEGAL EFFECTS

The classic Private International Law answer to undesired effects of deviating foreign regimes, is the invocation of public policy clauses. In various cross-border surrogacy cases such clauses have indeed been successfully relied upon. For instance, there have been examples where intended parents met with refusals by authorities in their home country to issue a passport to the child that was born with a surrogate mother in a foreign country. Even if the intended parents are able to enter their State with the child, they may still encounter problems in establishing parental links with the child. Various national courts have refused recognition to foreign birth certificates on which intended parents were stated as legal parents.[62] There have even been examples where the child was subsequently placed for adoption.[63] On similar grounds may courts refuse to enforce a foreign judgment declaring the intended parents the legal parents of the child.

In reproductive matters public policy grounds are often closely related to the interests of the child. In a German case of 2007, for instance, a Court refused to enforce the judgment of a Turkish court awarding the adoption rights over a child to a German couple who had arranged a surrogacy agreement with a Turkish family. The Court held this Turkish judgment to be against the child's best interests, as the child had only been given birth with the aim of being handed over to the German intended parents.[64] Another example of such reasoning can be found in Dutch law, where a birth certificate on which intended parents are stated as legal parents is considered contrary to public policy, *inter alia* because the child has the right to know his or her genetic origins.[65]

The interests of the child may, however, also lead to exactly opposite conclusions in cross-border surrogacy cases. In various such cases, it was (after all) held that the interest of the child in fact required the awarding of travel documents, or even the award of parental rights to the intended parents.[66] As a result the different foreign choice was thus *de facto* accommodated for. As further explained in section 3.2.1 below it is as yet an open question whether under European law States are under an obligation to take such an accommodating approach to cross-border surrogacy.

### 3.1.2 BANS ON INFORMATION ABOUT FOREIGN SERVICES

Cross-border movement in reproductive matters may also be warded off by means of bans on information about foreign treatment options. There have been a few cases before the European Courts where such bans had indeed been imposed in respect of foreign abortion services.

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[62] E.g. District Court The Hague (Rechtbank 's-Gravenhage), 24 October 2011, *LJN* BU3627. See also the cases pending before the ECtHR (*n* 30).

[63] See *Paradiso and Campanelli* (*n* 30).

[64] AG (Administrative Court) Hamm 13 March 2007, Az XVI 23/06. See also LG (State Court) Dortmund (dec.) 13 August 2007, *Az* 15 T 87/07.

[65] See I Curry-Sumner, *JPF* 2012/13 and S C A van Vlijmen and J H van der Tol, 'Draagmoederschap in opkomst: specifieke wet- en regelgeving noodzakelijk?', *FJR* 2012/56. See also District Court The Hague (Rechtbank 's-Gravenhage) 14 September 2009, *LJN* BK1197.

[66] See section 3.2.1 below.

In *Grogan* (1991) the CJEU did not decide the thorny issue whether an Irish prohibition on distribution of information regarding abortion services in the UK could be justified under EU law. The Court namely held that the link between the activity of the defendant student associations and medical terminations of pregnancies carried out in clinics in the UK was 'too tenuous' for the prohibition on the distribution of information to be capable of being regarded as a restriction within the meaning of (then) Article 59 of the Treaty.[67] The Advocate General in the case had instead addressed the justification question and had concluded that the information prohibition was not precluded under EU law.[68] No further cases on this particular issue have come before the CJEU since, but the Patient Mobility Directive, however, has introduced considerable rights to information for patients involved in cross-border care (see section 3.2.2 below).

The Irish ban on information about foreign abortion services subsequently proved problematic under the ECHR. In *Open Door* (1992) the ECtHR held an injunction restraining Irish counselling agencies from assisting pregnant women in seeking legal abortion services abroad, to violate the freedom to impart and receive information (Article 10 ECHR).[69] The Court was struck by the absolute nature of the injunction 'which imposed a "perpetual" restraint on the provision of information to pregnant women concerning abortion facilities abroad, regardless of age or state of health or their reasons for seeking counselling on the termination of pregnancy'. The Court further noted that the link between the provision of information and the destruction of unborn life was not as definite as contended; that information could be obtained from other sources in Ireland and that the restriction could not effectively protect the right to life of the unborn since it did not prevent large numbers of Irish women from continuing to obtain abortions in the UK. It also held that the injunction created a risk to the health of those women seeking abortions at a later stage in their pregnancy due to the lack of proper counselling and that it had adverse effects on women who were not sufficiently resourceful or did not have the necessary level of education to have access to alternative sources of information.[70]

Further authority for the claim that a refusal to provide information about foreign abortion services constitutes (or contributes to) a violation of the ECHR can be found in the the *A, B and C* case. As yet noted above, one of the elements of the justification of the restrictive Irish abortion laws was that women who travelled abroad for an abortion had access 'to appropriate information and medical care' in Ireland.[71]

Given the specific context of the Irish abortion cases, one may wish to be careful in applying these findings analogously to situations concerning AHR or surrogacy, but the reasoning concerning effectiveness and implications of the information ban, may very well hold in other CBRC cases.

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[67] Presently Article 56 TFEU. *Grogan* (*n* 26), para. 32.
[68] Advocate General van Gerven considered the restriction not disproportionate because the Irish prohibition did not ban all information but only information which assisted pregnant women to terminate unborn life. Opinion in *Grogan* (*n* 59), para. 35.
[69] ECtHR 29 October 1992, *Open Door and Dublin Well Woman v Ireland*, nos. 14234/88 and 14235/88.
[70] *Idem*, paras. 73-77.
[71] *A, B and C* (*n* 31), para. 241. See also 3.1.4 and 3.2.2 below.

### 3.1.3 REFUSALS OF REIMBURSEMENT AND PRIOR AUTHORISATION REQUIREMENTS

Another way for States to ward off foreign choices they consider undesirable or unethical, is through refusing reimbursement to individuals or couples who availed themselves of foreign treatment options or by setting prior authorization requirements. The basic rule under EU free movement law is that States do not have to reimburse treatment obtained abroad, if such treatment is prohibited under the domestic law, or if its national scheme does not provide for reimbursement for that kind of treatment.[72] Hence, if a State prohibits certain reproductive treatment, it is under no obligation to reimburse the costs if such treatment is obtained abroad. In practice, this rule may prove problematic in the context of reproductive treatment, however, as it may be debated if medical and ethical standards may be taken into account in this assessment.[73]

Whether prior authorisation requirements can be set for pregnancy terminations and AHR treatment (either or not involving surrogacy) is more questionable. Firstly, it is not clear if these can be, as necessary, qualified as so-called 'scheduled treatment'.[74] Further, under the Patient Mobility Directive a prior authorisation requirement for scheduled treatment can only be set if the treatment involves overnight hospital accommodation of the patient in question for at least one night or if it requires use of highly specialised and cost-intensive medical infrastructure or medical equipment.[75] As a rule no hospital accommodation is required for abortion and AHR treatment.[76] Whether any of these types of treatment involve 'highly specialised and cost-intensive medical infrastructure or medical equipment', within the meaning of the Directive is less obvious,[77] but new medical and technological developments may lead to different conclusions in this regard. Prior authorisation may also be refused on the basis of safety and quality concerns.[78] In the case of AHR treatment such a refusal may be barred, however, by the existence of minimum harmonization in this field by means of the Tissues and Cells Directive

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[72] Article 7 Directive 2011/24/EU. Additional costs, such as costs for board, lodging, travel, visitors' tax and the making of a final medical report, can also not be claimed in this situation. *Ludwig Leichtle*, C-8/02, judgment of 18 March 2004 [2004] ECR I-02641.

[73] For example, the Dutch Central Appeals Court for Public Service and Social Security Matters (Centrale Raad van Beroep) ruled in 2007 that IVF treatment with the use of anonymously donated egg-cells was not amongst the benefits provided for under the Dutch Health Insurance Act and that therefore a refusal to reimburse for such treatment obtained abroad, constituted no obstacle of the freedom to receive services (judgment of 31 January 2007, *LJN* AZ8510). The Health Care Insurance Board (*College voor zorgverzekeringen*') and the Dutch government had earlier taken a contrary position on the matter. Annex to Parliamentary Documents (*Kamerstukken II)* 33000-XVI no. 188, p. 6 and Parliamentary Documents (*Kamerstukken II*) 2010-2011 , Appendix (Aanhangsel) to Proceedings (*Handelingen*) no. 238, p. 1-2 and Health Care Insurance Board (*College voor zorgverzekeringen*) Opinion no. 26084415 of 24 October 2006.

[74] *Geraets-Smits and Peerbooms,* C-157/99, judgment of 12 July 2001 [2001] ECR I-05473, para. 76. From the ECJ's case-law it follows that in this regard, not so much the hospital environment, but the planning element of the treatment is decisive. *Müller-Fauré and van Riet*, C-385/99, judgment of 13 May 2003 [2003] ECR I-04509, para. 75 and *Commission v France*, C-512/08, judgment of 5 October 2010 [2010] ECR I-08833, para. 34.

[75] Article 8 (2) (a) Directive 2011/24/EU.

[76] Within the EU practices vary as to the place where abortions and AHR treatment take place; this may be in (special clinics within) hospitals or in private clinics. Generally, also in situations where the treatment is carried out in a hospital, no accommodation for the night is required.

[77] The CJEU has so far given only limited guidance on this point. See *Commission v France* (*n* @), para. 33-34.

[78] Article 8 (2) (c) Directive 2011/24/EU. See also W Palm and R Baeten, 'The quality and safety paradox in the patients' rights Directive', *Eur J Public Health* (2011) 21 (3), p. 273.

(see 2.1 above).[79] In respect of abortion, however, no such harmonisation is in place.

### 3.1.4 Refusals of follow-up care

At a more practical level protectionist responses may consist in refusals of providing aftercare. For example, in 2010 it was reported that fifty percent of the Dutch gynaecologists refused to provide treatment to women who had AHR treatment with the use of commercially and anonymously donated egg cells in Spain.[80] It is as yet an open question whether European law leaves room for such refusals. Under the EU Patient Mobility Directive a State of affiliation must ensure that the same medical follow-up is available 'as would have been if that healthcare had been provided on its territory.'[81] From this it could be concluded that there is no such obligation if the respective treatment is prohibited in the country of affiliation, but whether this is a correct reading of the relevant provision is insufficiently clear.

A refusal to provide follow-up care after abortion may contribute to a violation of the ECHR, as follows from the *A, B and C* case, where the Court considered access to medical care in Ireland after an abortion abroad a precondition for the justification of the very restrictive Irish abortion laws.[82] While there is no case-law on this point yet, it is well possible that such reasoning would also apply in CBRC cases. Refusals to provide (necessary) care may in any case in themselves prove incommensurable with fundamental rights and national codes of conduct for the medical profession.

## 3.2 Accommodation

Instead of warding them off, States may also in some way or another accommodate for the effects of deviating foreign choices in reproductive matters with which they are confronted through cross-border movement. Below accommodating responses are discussed that form the counterpart of the protectionist responses discussed in the previous section. The first concerns recognition of the legal effects of foreign treatment options (section 3.2.1). Less intrusive forms of accommodation may consist of information provision, reimbursement and follow-up care.

### 3.2.1 Recognition of legal effects

In various cross-border surrogacy cases national courts have taken an accommodating approach by recognising the legal effects of foreign options. For example, in several Dutch cases where the authorities had refused to issue a passport to a child born abroad following surrogacy, the Court ordered the Ministry of Foreign Affairs to issue emergency travel documents, as it

[79] Article 8 (2) (c) Directive 2011/24/EU.
[80] As stated by the spokesman of the Dutch Association for Gynaeclogists during an interview for the Dutch tv-programme *Nieuwsuur,* broadcasted on Dutch television on 9 September 2010, *online available* at <http://nieuwsuur.nl/onderwerp/183384-spanje-is-hoop-voor-onvruchtbare-vrouwen.html> (last accessed 30 March 2014).
[81] Article 5 (c) Directive 2011/24/EU.
[82] *A, B and C* (*n* 31), para. 241.

considered this to be dictated by the best interests of the child.[83] Accommodation may also have less an *ad hoc* character, by providing for the recognition of parental links established abroad, even if the formation of such links is not possible under the law of the home-state itself. Again in Dutch cross-border surrogacy cases, putting the interest of the child first instead led – as time elapsed – to the award of parental rights to (at least one of) the intended parents.[84] The Secretary of State for Security and Justice consequently concluded that as a result of the approach of the Dutch courts in surrogacy cases, standing policy was overtaken by practice and its enforcement was rendered more difficult. He therefore proposed that foreign surrogacy agreements would be given legal effect in the Netherlands if at least one of the commissioning parents was genetically related to the child and the other genetic parent was known. It was also proposed that the reimbursement of expenses for foreign surrogate mothers would not be taken into account in the examination of the public policy exceptions in international surrogacy cases, as – so he alleged – 'profit' could not be defined unequivocally in the international context.[85]

As the Dutch example shows, accommodation may thus be inspired or even dictated by overriding interests, such as the rights of the child. It is as yet an open question if EU (free movement) law also dictates an accommodation approach in cross-border surrogacy situations. In most situations where EU Member States refused recognition in cross-border surrogacy cases, the reproductive treatment involving the surrogacy agreement had taken place a third country.[86] Such situations fall outside the scope of EU law and there is thus under EU law no obligation on Member States to recognise court judgments or birth certificates from these countries. States can apply their own PIL-regimes in these cases.[87] This could be different, however, if another EU Member State is involved.

None of the existing EU PIL instruments applies to cross-border surrogacy cases,[88] but a refusal by an EU Member State to give recognition to a birth certificate issued in another Member States may prove problematic under EU law. If the intended parents are EU citizens they may rely on their free movement rights and they may also invoke the citizenship rights of the child.[89] Non-recognition of the birth certificate may well be considered a restriction of these free

[83] Summary proceedings judge (Voorzieningenrechter) District Court The Hague (Rechtbank 's-Gravenhage), 9 November 2010, *LJN* BP3764 and Summary proceedings judge (Voorzieningenrechter) District Court Haarlem 10 January 2011, *LJN* BP0426.

[84] E.g. District Court The Hague (Rechtbank 's-Gravenhage) 11 December 2007, *LJN* BB9844 and District Court The Hague (Rechtbank 's-Gravenhage) 18 January 2012, *LJN* BV2597.

[85] Parliamentary Documents (*Kamerstukken II*) 2011-2012, 33 000 VI, no. 69, p. 4.

[86] This for instance holds for all cases currently pending before the ECtHR (*n* 30).

[87] There is interesting work on surrogacy in progress within context of the Hague Conference on Private International Law. See <http://www.hcch.net/index_en.php?act=text.display&tid=178> (last accessed 29 March 2014).

[88] Regulation 2201/2003 sees at parental responsibility only, but does not cover the establishment of legal parenthood. See surrogacy report p. 154. There is furthermore no EU PIL-instrument on recognition of civil status documents, although the first explorative steps in this regard have been taken by the European Commission in its Green Paper 'Less bureaucracy for citizens: promoting free movement of public documents and recognition of the effects of civil status records, Brussels, 14.12.2010 COM(2010) 747 final. Lastly, (non-)contractual obligations arising out of family relationships are explicitly excluded from the scope of the relevant Regulations. See Article 1(2)(b) Regulation (EC) No 593/2008 ('Rome I') and Article 1(2)(a) Regulation (EC) No 864/2007 ('Rome II'). See Brunet a.o. 2013 (*n* 27), p. 148.

[89] Article 21 TFEU.

movement rights.[90] While public policy grounds may be accepted as justification for such a restriction, and while the CJEU has proven respectful for national identity arguments in cases concerning the spelling of names,[91] it is doubtful if such a case would pass the proportionality test. Forceful counter-arguments would namely be the rights of the child and the right to respect for family life, which States have to protect when they act within the scope of EU law.[92]

The latter consideration makes it even more interesting to see what approach the ECtHR will take in the currently pending cross-border surrogacy cases.[93] It is possible that this Court rules that States are under the Convention under an obligation to take an accommodating approach. In fact, the ECtHR has already taken such an approach in a cross-border adoption cases. In *Wagner* Luxembourg courts had refused to have an adoption decision pronounced in Peru declared enforceable in Luxembourg, because Luxembourg law made no provision for full adoption by a single woman.[94] The ECtHR ruled that Article 8 ECHR had been violated, because the Luxembourg courts failed to acknowledge the family ties created by the full adoption granted in Peru.[95] The ECtHR has more often stressed the importance of granting legal recognition to *de facto* family life and in cross-border surrogacy cases this may prove a decisive consideration.[96] It may, however, depend on the circumstances of each cross-border surrogacy case whether such *de facto* family life can be said to have (yet) been established.

A further hint that the Court may adopt an accommodation reasoning in the pending surrogacy cases may be found in *S H and Others* where the Court noted that there was 'no prohibition under Austrian law on going abroad to seek treatment of infertility that uses artificial procreation techniques not allowed in Austria and that in the event of a successful treatment the Civil Code [*contained*] clear rules on paternity and maternity that respect the wishes of the parents.'[97] Hence, while the ECtHR did not rule in this case that States are obliged under the Convention to recognise the legal effects of foreign treatment options, it accepted such recognition as an element contributing to the justification for prohibiting such treatment in the home country.

While the current case-law of the CJEU and the ECtHR does not provide a conclusive answer on this point yet, it is thus well possible that fundamental rights as protected under European law require States to take an accommodation approach in cross-border surrogacy cases, by recognising parental links lawfully established in another (Member) State.

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[90] *Dafeki* supports this finding, although this case must be distinguished from the here discussed cross-border surrogacy scenario on two points: (1) it the free movement of workers and (2) in this case a birth certificate was refused recognition because it was rectified changing the date of birth. *Dafeki*, C-336/94, judgment of 2 December 1997 [1997] ECR I-6761.

[91] *Sayn-Wittgenstein*, judgment of 22 December 2010 [2010] ECR I-13693 and *Runevič-Vardyn*, C-391/09, judgment of 12 May 2011 [2011] ECR I-03787.

[92] See section 2.1 above.

[93] See *n* 30.

[94] ECtHR 28 June 2007, *Wagner and J M W L v Luxembourg*, no. 76240/01. The Court adopted a similar reasoning another cross-border adoption case: ECtHR 3 May 2011, *Negrepontis-Giannisis v Greece*, no. 56759/08.

[95] The Court also found a violation of Article 14 (prohibition of discrimination) taken in conjunction with Article 8, because the child (and her mother as a result) had been penalised in her daily life on account of her status as the adoptive child of an unmarried mother of Luxembourg nationality whose family ties created by a foreign judgment were not recognised in Luxembourg.

[96] *X and Others* (*n* 53), para. 145.

[97] *S. H. and Others* (*n* 33), para. 114.

### 3.2.2 INFORMATION, REIMBURSEMENT AND FOLLOW-UP CARE

States may also accommodate cross-border movement by providing independent information about foreign treatment options, by reimbursing treatment obtained abroad or by providing follow-up care. As these accommodating responses in fact form the mirror image of the protectionist responses discussed in sections 3.1.2-3.1.4 they are here jointly discussed under reference to the aforementioned sections.

As yet noted above, bans on information about foreign abortion services are incommensurable with the ECHR.[98] In fact, from *A, B and C* it can be inferred that States have an obligation to provide for access to 'appropriate' information about abortion services in other countries.[99]

Further, by introducing considerable rights to information for patients involved in cross-border care, the EU Patient Mobility Directive imposes certain accommodation obligations on the Member States.[100] National contact points in each Member State are to deliver information to patients involved in cross-border care concerning healthcare providers; information on the relevant standards and guidelines; information on patients' rights, complaints procedures and mechanisms for seeking remedies, as well as the legal and administrative options available to settle disputes, including in the event of harm arising from cross-border healthcare.[101] Furthermore, in the Member State of affiliation, mechanisms have to be put in place to provide patients on request with information on their rights and entitlements relating to receiving cross-border healthcare, 'in particular as regards the terms and conditions for reimbursement of costs […] and procedures for accessing and determining those entitlements and for appeal and redress if patients consider that their rights have not been respected […].'[102] Healthcare providers in the State where the treatment takes place, for their part, have to provide relevant information on the availability, quality and safety of the healthcare they provide, to help individual patients to make an informed choice.[103] The Directive does not oblige Member States to deliver information in other languages than their official languages.[104]

States may also accommodate cross-border movement in reproductive matters by providing for reimbursement for treatment obtained abroad, even if the treatment is not available in their own state. As explained above, under EU law states are free to do so, but whether they are also under an obligation accommodate cross-border movement in reproductive matters in this way, is a matter that has not yet been conclusively decided.[105] There are in any case presently no indications in the ECtHR case-law that hint in the direction of any such obligation.

Lastly, accommodation may take place through providing the necessary follow-up care upon return to the home country. As discussed in section 3.1.4 it is insufficiently clear whether under

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[98] See section @2.2.
[99] *A, B and C* (*n* 31), para. 241.
[100] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare, *OJ* L88/46 (4.4.2011).
[101] Articles 4 (2) (a) and 6 (3) Directive 2011/24/EU. The Directive makes a distinction between responsibilities of the Member State of treatment (Article 4) and responsibilities of the Member State of affiliation (Article 5). It is however inescapable that all Member States have to meet all requirements, as they may function both as States of treatment and States of affiliation.
[102] Article 5 (b) Directive 2011/24/EU.
[103] Article 4 (2) (b) Directive 2011/24/EU.
[104] Article 4 (5) Directive 2011/24/EU.
[105] See section 3.1.1 above.

EU law States are under an obligation to provide such aftercare. Under the ECHR access to appropriate follow-up care has in any case been set as a minimum accommodation obligation in cross-border abortion cases.[106] It is very well possible that in future case-law the Court defines a similar obligation in situations involving CBRC.

## 3.3 OUTSOURCING

Cross-border movement in reproductive matters may also be considered by States as a safety valve, a means to 'hide behind' the more permissive regimes of other States. The existence of foreign options may take away internal pressure for change and may in fact result in inactivity by the legislature. For proving such a claim in the present context, further (sociological) research is needed, which goes outside the scope of this paper. What has become clear, however, from the ECtHR's judgments in *A, B and C v Ireland* and *S H and Others v Austria*, is that this Court has indeed allowed States to hide behind other States' regimes, and outsource the protection of rights under the ECHR in these sensitive matters.[107] In both judgments foreign treatment options were accepted as an element contributing to the justification of prohibitive laws in reproductive matters.

This outsourcing approach – entailing that for meeting its obligations under the Convention a Contracting Party can refer to the laws of other States – raises a number of practical questions that have as yet not been addressed by the Court. For example, one may wonder whether the foreign treatment option must also be an effective option and whether distance to the foreign option makes a difference in this regard.[108]

More fundamentally, the outsourcing approach does not fit in well with the foundations and objectives of the ECHR, following which each State is responsible for securing the Convention rights to everyone within their jurisdiction.[109] It is moreover not a very principled approach; it is difficult to understand why certain interests that have been accepted as a justification for restrictive laws on reproductive matters – such as the best interests of the child, or protection of the unborn – would no longer hold in cross-border situations.[110] In fact precisely in cross-border situations may such interests require even more protection. Also, in these two judgments the Court failed to take into account that to resort to foreign options may involve practical difficulties and costs, which may in itself be problematic under the Convention.[111]

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[106] *A, B and C* (*n* 31), para. 241.
[107] See section 2.2 above.
[108] N.R. Koffeman, 'Het Ierse abortusverbod en het EVRM; is uitbesteding de nieuwe norm?', *NTM/NJCM-Bulletin*, p. 372-374.
[109] See Article 1 ECHR.
[110] See the dissenting opinion to *S H and Others* (*n* 33). See also R F Storrow, 'Judicial review of restrictions on gamete donation in Europe', *Reproductive BioMedicine Online* (2012) 25, p. 657 and I G Cohen, 'S.H. and Others v. Austria and circumvention tourism', *Reproductive BioMedicine Online* (2012) 25, p. 662.
[111] See the dissenting opinion to *S H and Others* (*n* 33). In their joint partly dissenting opinion to *A, B and C* (*n* 33), Judges Rozakis, Tulkens, Fura, Hirvelä, Malinverni and Poalelungi qualified the Court's reasoning on this point as 'circular' (para. 8).

# 4. CONCLUSIONS

European law explicitly allows for the existing diversity between the legal regimes of the EU Member States in reproductive matters. States are left room to make their own principled choices in these moral and ethical issues. However, once they decide to regulate in the area, they must also guarantee that the relevant legislation is coherent and provides for effective rights, which are moreover granted in a non-discriminatory manner. There is thus increasingly more implicit European influence on national standard-setting in reproductive matters.

The room that is allowed to States to respond to cross-border movement in reproductive matters is potentially more limited. The present analysis has shown that warding off (the effects of) cross-border movement in reproductive by means of non-recognition of legal effects of foreign option or by means of bans on information on foreign treatment options may not be easily justified under European law. Refusing follow-up care may also be problematic. While a refusal to reimburse the costs of treatment obtained abroad may be acceptable, it is questionable whether prior authorisation requirements can be set.

In fact, certain minimum accommodation obligations follow from European law and there is potential for these obligations to develop. The provision of independent information about foreign treatment options is required in all reproductive matters. An obligation to provide follow-up care is obligatory when a woman has had an abortion abroad, and may well be upheld in other CBRC situations. Further, even though this issue has not yet been decided by the CJEU, it is possible that, should a cross-border surrogacy case be brought before it, this Court will rule that fundamental rights as protected under EU law, such as the rights of the child, require that EU Member States recognise parental links legally established in another Member State. A similar obligation may follow from the ECHR, and may thus potentially also hold if third countries are concerned. The *faits accomplis* with which States may be confronted as a result of cross-border movement in reproductive matters, in combination with the legitimacy of the regimes where these were established may thus prove forceful arguments for narrowing the room for manoeuvre for States in such cross-border situations.

These (and potential other) accommodation obligations may be required by interests and perspectives that must be taken into account in all reproductive matters, but that may gain particular importance in cross-border situations. Clear examples are the rights of the child and the protection of (*de facto*) family life, but human dignity and equality may potentially also prove relevant. Other perspectives that hold especially in cross-border cases involving reproductive matters may become even more important in the future. Here, one may think of the burdensome character of cross-border movement in itself and of undesired implications of cross-border movement for the destination countries, such as the potential risk of exploitation of women in less wealthy countries who are involved in CBRC as egg-cell donor or surrogate mother.[112]

The here discussed accommodation obligations do not necessarily stand in the way of moral pluralism in reproductive matters.[113] States will only be required to facilitate cross-border

[112] Storrow has also warned for deleterious spill-over effects in destination countries. R Storrow, 'The pluralism problem in cross-border reproductive care', *Hum. Repr*. (2010) 25, p. 2939-2943.
[113] *Idem*.

movement and to recognize the effects of foreign options, but will not be obliged to adapt their national laws to these deviating foreign standards. On the other hand, the implicit reforming pressure of such recognition on the national laws cannot be overlooked.

Outsourcing instead takes away pressure for internal reform. One may, however, wonder whether foreign options can indeed justify more restrictive laws in the home country.[114] By only allowing for outsourcing when certain accommodation obligations are met, the ECtHR has nonetheless set certain minimum standards that apply to all ECHR Contracting Parties, including those with less permissive regimes in reproductive matters. In the relevant cases the Court simply took into account what was already provided for under the national laws of the respective State. Future case-law will therefore have to make clear whether any further such accommodation obligations will be defined.[115]

All in all, national regimes in reproductive matters have proven not immune for the effects of deviating regimes of other (European) States. It is profoundly through cross-border movement and in cross-border situations that States may experience that a complete isolated position in reproductive matters may be no longer tenable in the EU's multilevel legal order.

[114] *Idem* and W van Hoof and G Pennings, 'The consequences of S.H. and Others v. Austria for legislation on gamete donation in Europe: an ethical analysis of the European Court of Human Rights judgments', *Reproductive BioMedicine Online* (2012) 25, p. 668.

[115] One may think of an obligation to enable 'patients' to obtain insurance, to financially supporting the travelling or to make such travelling practically possible, for example in detention situations. See Koffeman 2011 (*n* 108).